# INSTRUCTIONS FOR COMPLETING THE 2005 RYAN WHITE CARE ACT DATA REPORT

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# INSTRUCTIONS FOR COMPLETING THE RYAN WHITE CARE ACT DATA REPORT

## WHO COMPLETES THE CARE ACT DATA REPORT?

The Ryan White CARE Act Data Report (CADR) should be completed by all Ryan White CARE Act Title I, II, III, and IV-funded grantees, service providers, and Title II consortia.

*Grantee of record* is the official Ryan White CARE Act grantee that receives Federal funding directly from the Health Resources and Services Administration (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted.

The *service provider* is the agency that provides direct services to clients and their families and is funded by the Ryan White CARE Act. Services may be directly funded by one or more Titles of the Ryan White CARE Act grants or through subcontract(s) with official Ryan White CARE Act grantees of record.

If the only services you provided during this reporting period were (1) planning or evaluation, (2) administrative or technical support, (3) fiscal intermediary services, (4) technical assistance, (5) capacity development, or (6) quality management, please complete Section 1, Items 1–16 only.

Providers who receive funds under more than one Title should complete this form ONLY once. Include information from all Titles under which you are funded and submit identical copies to all grantees from whom you receive CARE Act funds.

Each grantee of record should assemble all report forms completed by their providers, then complete one cover page and attach it to the assembled batch of completed forms. The grantee should then submit this entire package to the HAB data contractor.

## WHICH CLIENTS SHOULD BE INCLUDED IN THE CARE ACT DATA REPORT?

Providers should report on all clients who received services **eligible** for CARE Act Title I, II, III, or IV funding, regardless of the actual funding source used to pay for those services.

Grantees and providers who choose to report only on the subset of clients who received services funded by CARE Act Title funds (See Section 1, Part 1.2: Reporting scope for more information) must have special permission from their HRSA Project Officer.

## SECTIONS OF THE CARE ACT DATA REPORT

The CARE Act Data Report is divided into seven sections. Each section is then divided into various parts to be answered by the appropriate Title program. Not all Title programs are required to respond to each section; some parts are specific to Titles III and IV. Only programs administering a Health Insurance Program (HIP) should complete Section 7.

### Who Completes Each Section?

| Title | I | II | III | IV and IV Adolescent Initiative |
|---|---|---|---|---|
| Section 1. Service Provider Information | ✓ | ✓ | ✓ | ✓ |
| Section 2. Client Information | ✓ | ✓ | ✓ | ✓ |
| Section 3. Service Information | ✓ | ✓ | ✓ | ✓ |
| Section 4. HIV Counseling and Testing | ✓ | ✓ | ✓ | ✓ |
| Section 5. Medical Information | ✓ | ✓ | ✓ | ✓ |
| Section 6. Demographic Tables/ Title-Specific Data for Titles III and IV | | | | |
| Part 6.1. Title III Information | | | ✓ | |
| Part 6.2. Title IV Information | | | | ✓ |
| Section 7. Health Insurance Program Information | ✓ | ✓ | | |

### Section 1. Service Provider Information

*Part 1.1. Provider and Agency Contact Information*

Contact information of the person responsible for the CARE Act Data Report as well as the name, address, and taxpayer ID number for the agency

*Part 1.2. Reporting and Program Information*

Dates of the reporting period for the data in the report, client reporting scope, provider type, ownership status, source of Ryan White Care Act funding, target population, funding received, and staffing

### Section 2. Client Information

Total clients receiving services during the reporting period, new clients, gender, age, race/ethnicity, household income, living/housing arrangements, insurance, HIV/AIDS status, and vital/enrollment status

### Section 3. Service Information

Services offered and total number of clients receiving those services

### Section 4. HIV Counseling and Testing

Number of clients who received HIV counseling and testing, type of HIV counseling and testing, posttest counseling, number of clients who tested positive for HIV antibodies, and partner notification

### Section 5. Medical Information

Risk factors, testing and treatment, opportunistic infections, and pregnancy

### Section 6. Demographic Tables / Title-Specific Data for Titles III and IV

*Part 6.1. Title III Information*

Demographic tables of clients who were HIV-positive and who received at least one primary health care service by race/ethnicity, gender, age, and HIV exposure category; total cost of providing services, sources of income, and available services

*Part 6.2. Title IV Information*

Demographic tables of clients who are HIV-positive as well as affected partner/family member(s) by gender, race/ethnicity, age, and HIV exposure category

### Section 7. Health Insurance Program (HIP) Information

Annual expenditures, number of unduplicated clients receiving HIP, and funding received from Eligible Metropolitan Areas (EMAs) and other sources

# QUALITY ASSURANCE CHECKLIST

**We highly recommend that you use the following checklist to ensure the quality and reliability of the data that you report in the CARE Act Data Report.**

- ☐ This report includes information on all clients served and services delivered between January 1 and December 31 of the reporting year (not based on your fiscal calendar).
- ☐ The **full name** of the agency was given in Item 1. If an acronym is commonly used for the agency name, the definition of the acronym was provided.
- ☐ A valid nine-digit taxpayer ID was reported in Item 2d.
- ☐ If this report was prepared using the ***eligible reporting scope "01"*** (Item 6), it includes all clients receiving services eligible to be paid for with CARE Act funds, regardless of whether CARE Act funds were actually used to pay for the services. If this report was prepared using the ***funded-only reporting scope "02"*** (Item 6), it **only** includes clients receiving services funded by the CARE Act.
- ☐ **All** sources of CARE Act funding were reported in Item 10. For each source of funding reported, the actual amount of funding ***received*** was reported in Items 11-14.
- ☐ Full-time equivalents were reported in Items 21 and 22 for paid and volunteer staff, **not** the actual number of staff members.
- ☐ The funding information reported in Items 11-14 is annualized to reflect the calendar year, **not** the agency's fiscal year.
- ☐ The total number of new clients reported in Item 24 is **less than or equal to** the total number of clients reported in Item 23.

  **NOTE:** The total number of new clients in Item 24 should **only** be equal to the total number of clients in Item 23 if the agency is newly funded by the Ryan White CARE Act, in which case all of the clients are new to the agency.
- ☐ All client totals in Section 2, Items 25-32 must **equal to** the total number of unduplicated clients reported in Item 23.
- ☐ The number of clients seen for any given service, as reported in each row of Item 33, does **not exceed** the total number of unduplicated clients reported in Item 23. If the number of clients that were seen for a given service is unknown, column 3b in Item 33 is checked.
- ☐ The number of visits for any given service reported in column 4a of Item 33 is **greater than or equal to** the number of clients reported for that service in column 3a. If the number of visits for a given service is unknown, column 4b in Item 33 is checked.
- ☐ If counseling and testing services were reported in Section 4: Item 37 is **less than or equal to** Item 36, Item 38 is **less than or equal to** Item 37, Item 39 is **less than or equal to** Item 37, and Item 40 is **less than or equal to** Item 38.
- ☐ **All clients who are HIV-positive** reported in Section 3, Item 33a: Ambulatory/outpatient medical care have also been reported in Section 5, Item 42 (To restate, the total number of clients reported in Item 42 is **equal to** the total number of clients reported in Item 33a).
- ☐ If Section 5 was completed, the total number of clients reported in Item 43 is **equal to** the total number of clients reported in Item 42.
- ☐ If the agency receives Title III funding, Section 6.1 is completed. The total number of clients reported in Items 55-61 must be **equal**. In addition, the total number of clients reported also in Item 55-61 must be **less than or equal to** the total number of clients reported in Item 23.
- ☐ If the agency receives Title IV funding, Section 6.2 is completed. The total number of clients reported in Items 66-73 must be **equal**. In addition, the total number of clients reported in each item must be **less than or equal to** the total number of clients reported in Item 23.

## COVER PAGE

*All Ryan White CARE Act grantees of record should complete the cover page. The completed and signed cover page should either be faxed to Attn: Ryan White CARE Act Data at (703) 312-5230 or mailed to WRMA/CSR Ryan White Project, Attn: Ryan White CARE Act Data, 2107 Wilson Boulevard, Suite 1000, Arlington, VA 22201.*

### Grantee of record

Enter the agency name of the grantee of record if different from provider.

*Grantee of record* is the official Ryan White CARE Act grantee that receives Federal funding directly from the Federal Government (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted. The name of the grantee of record should match the name on the notice of grant award.

### Grantee of record taxpayer ID number

Enter the nine-digit taxpayer ID number of the agency listed above. This number is provided to the agency by the Internal Revenue Service. It is a taxpayer identifying number issued to an organization or agency, upon application, for use in connection with filing requirements.

### D-U-N-S Number

A number assigned by Dun & Bradstreet that indicates your organization's credit worthiness. D-U-N-S numbers can be requested from www.dnb.com.

### Grantee type

Indicate the Title(s) for which the agency is the grantee of record. Check all that apply.

REMEMBER: Each grantee of record is responsible for their provider reports. If hard copies are submitted, the grantee should assemble all report forms completed by their providers, then complete one cover page and attach it to the assembled batch of completed forms. The grantee can either enter the data online or submit this entire package via mail to the HAB contractor. Grantees have the option of allowing providers to enter their data online. Grantees are required to review and approve the data submitted by each of their providers online.

### Grant Number

Enter the HRSA-designated grant number for each Title indicated above. This number is found on the grantee of record notice of grant award.

### Number of providers

Indicate the total number of providers reporting data under each Title for this reporting period.

### Number of CADRs

Indicate the total number of CADRs being submitted under each Title for this reporting period.

### Total number of agencies

Indicate the total unduplicated number of agencies that received CARE Act funding from the grantee of record. If the grantee of record is also a service provider, it should be included in this count. This number should be the same as the number of providers reported on the grantee of record Provider Verification Form.

### Total number of CADRs

Indicate the total number of online and paper CADRs included in your submission package.

### Quality assurance personnel

Enter the name and signature of the grantee of record representative responsible for verifying the data found in this report.

### Grantee contact e-mail

Enter an e-mail address for a contact from the agency listed above.

## SECTION 1. SERVICE PROVIDER INFORMATION

*This section should be completed by all service providers and/or grantees funded through Ryan White CARE Act Titles I, II, III, and IV.*

### Part 1.1. Provider and Agency Contact Information

1. **Provider name**

Give the name of the service provider for whom this data report is being completed. If an acronym is used for an agency's name, please include the definition of the acronym.

*Items 2 through 3e refer to the provider agency listed in Item 1.*

2. **Provider address**

a. **Street**

Enter the street address of the provider listed in Item 1 (where service is provided).

b. **City and state**

Enter the city and state of the provider listed in Item 1.

c. **ZIP Code**

Enter the ZIP Code of the provider listed in Item 1.

d. **Taxpayer ID #**

Give the unique nine-digit taxpayer ID number (also called an EIN) of the provider agency. This number, issued by the Internal Revenue Service, serves as an organization's or agency's taxpayer identification number, upon application, for use in connection with filing requirements. Self employed individuals who serve as providers should use their Social Security Number.

3. **Contact information**

a. **Name**

Enter the name of the contact person at the provider agency listed in Item 1 who is responsible for completing the data in this report.

b. **Title**

Enter the title of the person listed in Item 3a.

c. **Phone #**

Enter the telephone number, including area code, of the person listed in Item 3a.

d. **Fax #**

Enter the fax number, including area code, of the person listed in Item 3a.

e. **E-mail**

Enter the e-mail address of the person listed in Item 3a.

4. **Person completing this form**

a. **Name**

Enter the name of the person completing the form at the provider agency, as defined in Item 1.

b. **Phone #**

Enter the telephone number, including area code, of the person listed in Item 4a.

c. **E-mail**

Enter the e-mail address of the person listed in Item 4a.

## Part 1.2. Reporting and Program Information

5. **Reporting period**

Enter the start and end dates of the reporting period for the provider agency.

*Reporting period* is a calendar year, January 1 through December 31. The data are reported to HRSA by the following March 15.

All information reported on clients and service delivery should reflect the calendar year reporting period.

The reporting period may be shorter than a year if a provider agency did not receive CARE Act Title funding for an entire calendar year. In this case, the beginning or end dates of the reporting period should reflect the exact time period in the calendar year during which services were delivered to clients. For example, the reporting period for a provider whose contract began on April 1 would be April 1–December 31. Similarly, the reporting period for a provider whose contract was effective on January 1 but discontinued on June 30 would be January 1–June 30.

6. **Reporting scope**

Indicate the reporting scope for the collection of the data in this report using the predetermined response codes listed below. Select only one response code.

***Code 01:*** ALL clients receiving a service ELIGIBLE under the Title for which the grantee is funded (which varies by Title I, II, III, or IV funding).

*Explanation: Reporting scope for providers reporting ELIGIBLE services*. Data are based

on all services that are eligible for funding from Ryan White Title I, II, III, or IV.

Please refer to Section 3, Item 33 for a complete list of ELIGIBLE service categories.

Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Title I, II, III, or IV funding are included in the report even if the service was not paid for with Ryan White Title I, II, III, or IV funds. ***This reporting scope is preferred by HRSA.***

***Code 02:*** ONLY clients receiving a Title I, II, III, or IV FUNDED service.

*Explanation: Reporting scope for providers reporting FUNDED clients*. Data are based on clients for whom services are paid for by Ryan White Title I, II, III, or IV funding.

Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White Title I, II, III, or IV funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must:

- Have an adequate mechanism for tracking clients and services by funding stream;
- Have secured prior approval from their grantee in consultation with HRSA; and
- Report actual numbers of clients and services not estimates.

7. **Provider type**

Using the provider types listed below, select the type of provider that best describes the agency completing this data report. **Check only one.**

a. **Provider types:**

*Hospital or university-based clinic* includes ambulatory/outpatient care departments/outpatient medical care or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs.

*Publicly funded community health center* includes community health centers, migrant health centers, rural health centers, and homeless health care centers. If you select this answer, you must answer Item 7b.

*Publicly funded community mental health center* is a community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people.

*Other community-based service organization* (CBO) includes non-hospital-based organizations, AIDS service and volunteer organizations, private nonprofit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers.

*Health department* includes State or local health departments.

*Substance abuse treatment center* is an agency that focuses on the delivery of substance abuse treatment services.

*Solo/group private medical practice* includes all health and health-related private practitioners and practice groups.

*Agency reporting for multiple fee-for-service providers* is an agency that reports data for more than one fee-for-service provider (e.g., State operating a reimbursement pool).

*PLWHA (*People Living with HIV/AIDS) *coalition* includes organizations that provide support services to individuals and families infected with and/or affected by HIV and AIDS.

*VA facility* is a facility funded through the Veterans Administration.

*Other facility* includes facilities other than those listed above.

b. **Section 330 of PHSA funding**

Check whether or not you received funding under Section 330 of the Public Health Service Act (PHSA) during the reporting period. Section 330 is a section of the PHSA that funds community health centers, migrant health centers, and health care for the homeless.

*Section 330 of PHSA* supports the development and operation of community health centers, migrant health centers, and health care for the homeless that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations.

8. **Ownership status**

Using the categories defined below; check the box that best describes the provider's status of incorporation. **Check only one**.

a. **Types of ownership status:**

*Public/local ownership* indicates that an organization is funded and operated by a local government entity. An example is a city health department.

*Public/State ownership* indicates that an organization is funded and operated by a State government entity. An example is a State health department.

*Public/Federal* indicates that an organization is funded and operated by the Federal Government. An example is a Federal agency.

*Private, nonprofit* indicates that an organization is owned and operated by a private, not-for-profit entity, such as a nonprofit health clinic. If you select this answer, you must answer Item 8b.

*Private, for-profit ownership* indicates that an organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.

*Unincorporated* indicates that an agency is not incorporated.

*Other* indicates an agency is owned by someone other than those listed above.

b. **Faith-based organization**

If you selected "private, nonprofit" for ownership status, indicate whether or not the agency receiving funding is a faith-based organization.

*Faith-based organization* indicates that the organization is owned and operated by a religiously affiliated entity, such as a Catholic hospital.

9. **Minority AIDS Initiative (MAI) funding**

Indicate whether or not the organization received MAI funds during the reporting period.

*MAI* is a national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

10. **Source of funding**

Check the provider agency's source(s) of funding under Ryan White CARE Act Titles I, II, III, or IV. **Check all that apply**. This item includes funding that is received directly from the Federal Government (grantee), through a subcontract with a CARE Act grantee (service provider), or through Title II funding to a consortium. For each source of funding checked, please also indicate the name of each grantee from whom funding was received. If you are the grantee of record please write the name of your agency next to the appropriate funding source.

**Data Quality Check**
For each source of funding checked in Item 10, the actual amount of funding received must be reported in Items 11–14.

*Title I* of the Ryan White CARE Act provides direct financial assistance to designated EMAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals with HIV disease and their families; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.

*Title II* of the Ryan White CARE Act authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. The CARE Act emphasizes that such care and support be part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.

*Title III EIS* of the Ryan White CARE Act provides support for early intervention services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This specifically includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management and eligibility assistance.

*Title IV* of the Ryan White CARE Act supports coordinated services and access to research for women, infants, children, and youth with HIV disease and their affected family members.

*Title IV Adolescent Initiative* is a separate grant under the Title IV program that is aimed at identifying adolescents who are HIV-positive and enrolling them in care.

11. **Title I funding**

a. **Title I funding received**

Indicate the total dollar amount of Title I (EMA) funds RECEIVED (rounded to the nearest dollar) by the service provider during the reporting period, regardless of the amount of funds actually expended by your organization.

b. **Title I MAI funding**

Of the amount of Title I funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

12. **Title II funding**

a. **Title II funding received**

Indicate the total dollar amount (rounded to the nearest dollar) of Title II (State/consortium) funds received during the reporting period, regardless of the amount of funds actually expended by your organization.

b. **Title II MAI funding**

Of the amount of Title II funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

13. **Title III EIS funding**

a. **Title III EIS funding received**

Indicate the total dollar amount (rounded to the nearest dollar) of Title III EIS funds received during the reporting period, regardless of the amount of funds actually expended by your organization.

b. **Title III EIS MAI funding**

Of the amount of Title III EIS funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

14. **Title IV funding**

a. **Title IV funding received**

Indicate the total dollar amount (rounded to the nearest dollar) of Title IV funds received during the reporting period, regardless of the amount of funds actually expended by your organization. In addition, please include any funds received under the Title IV Adolescent Initiative.

b. **Title IV MAI funding**

Of the amount of Title IV funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

**Data Quality Check**
For each amount of funding reported in Items 11-14, the corresponding funding source must be checked in Item 10.

**NOTE:** Although funding reported by providers will not match grant awards exactly due to administrative costs, delays in contract awards, and carry-over funds, the sum of grant awards falling within the calendar year and the ***annual HIV/AIDS***

***funding*** amounts reported in Items 11–14 should be reasonably similar. In addition, for Items 11–14, all funding should be annualized to reflect the reporting period as shown below.

**How to Annualize Fiscal Information***

***Example:***

*Annualizing fiscal information*—A provider received funding from these sources in 2005:

- $120,000 from Source A for a fiscal year beginning 10/1/2004 and ending 9/30/2005.
- $240,000 from Source B for a fiscal year beginning 3/1/2004 and ending 2/28/2005.
- $120,000 from Source C for the time period 12/1/2004 through 11/30/2005.

***Follow a two-step process for each funding source: First calculate the funding amount per month and then the number of months this amount was received in 2005.***

**Source A:**

- $120,000 / 12 months = **$10,000** per month
- $10,000 per month x 9 months (January–September) of 2005 = **$90,000**

**Source B:**

- $240,000 / 12 months = **$20,000** per month
- $20,000 per month x 2 months (January–February) of 2005 = **$40,000**

**Source C:**

- $120,000 / 12 months = **$10,000** per month
- $10,000 per month x 11 months (January–November) of 2005 = **$110,000**

***NOTE: This information is being "annualized" and may or may not equal the amount received in the funding cycle.**

15. **Oral health care expenditures**

Indicate the total amount of Ryan White CARE Act funds **EXPENDED** (rounded to the nearest dollar) on oral health care during the reporting period. If no funds were spent, report "0" in the space provided.

16. **Service provided to grantee of record**

For each of the six services listed, indicate whether the service was provided to the grantee of record by the service provider by checking "Yes" or "No" for each item. If the grantee of record is the service provider, indicate whether the service was provided by checking "Yes" or "No" for each item.

**NOTE:** If any of these services were the ***only*** services provided with CARE Act funding, **STOP HERE** and do not complete the remainder of this form. Third-party administrators who process fee-for-service reimbursements to providers of eligible services should continue with Item 17a.

*Planning or evaluation* is the systematic (orderly) collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, to identify needed improvements, and/or to make future programming decisions.

*Administrative or technical support* is the provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management, and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).

*Fiscal intermediary services* include reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.

*Technical assistance* (TA) is the identification of need for, and delivery of, practical program and technical support to the CARE Act community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act-supported planning and primary care service delivery systems.

*Capacity development* is a set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost-effectiveness of such services. These competencies also sustain the infrastructure

and resource base necessary to develop and support these services. Core competencies include: management of program finances; effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; service evaluation; and cultural competency development.

*Quality management* is a systematic process with identified leadership, accountability, and dedicated resources, that uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.

### 17. a. ADAP or other APA program

Indicate whether the provider agency administered an AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance (APA) program during the reporting period. If your answer is "Yes," continue with Item 17b. If your answer is "No," skip to Item 18.

ADAP is typically a centrally administered program operated at the State level that receives both Ryan White CARE Act Title II ADAP-earmarked and Title II base funds. Other AIDS Pharmaceutical Assistance programs typically operate at the local EMA or consortia level. Funds for these programs may come from a variety of sources that are not federally earmarked for AIDS medications. These may include Title I and private sources.

*ADAP* is a State-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

*APA* program is a local pharmacy assistance program implemented by a Title I EMA or Title II State. The Title II grantee consortium or Title I planning council contracts with one or more organizations to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White contract with their grantee or other funding sources.

Programs are considered a local APA if they provide HIV/AIDS medications to clients and meet ***all*** of the criteria listed below:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are ***not*** local APAs if they dispense medications in one of the following situations:

- Medications are dispensed to a client as a result or as a component of a primary medical visit;
- Medications are dispensed to a client on an emergency basis (an emergency basis is defined as a single occurrence of short duration); or
- Money or cash vouchers are given to a client to procure medications.

### b. Type of pharmaceutical program

If your agency administers an ADAP or other APA program, specify the program type:

- State ADAP
- Local APA program.

**STOP HERE** if this is the only service you provide.

### 18. Health Insurance Program (HIP) assistance

Indicate whether or not you provided health insurance through HIP (with Ryan White CARE Act funds) during the reporting period. If this was the ***only*** service you provided under CARE Act funding, skip to Section 7. Health insurance paid for with ADAP funds is not considered HIP.

*HIP* is a program that makes premium payments, co-payments, deductibles, or risk pool

payments on behalf of a client to keep his or her private health insurance active.

19. **Target population**

Check the box next to each population group that the program specifically targeted (i.e., set as a goal to achieve and directly allocated funds to support) for outreach efforts or service delivery during the reporting period. The program caseload of clients who are HIV-positive may not be entirely representative of the target populations indicated. If other populations that are not listed here were targeted, check "Other."

*Target population* is a population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

20. **Minority group membership of agency**

Check the categories that best describe your agency. **Check all that apply.**

21. **Total paid staff**

Report the number of paid staff, in full-time equivalents (FTEs) that were funded by the CARE Act during this reporting period. See the text box on this page for information on how to calculate FTEs.

22. **Total volunteer staff**

Report the total number of volunteer staff (at all sites within your overall program) in full-time equivalent positions dedicated to HIV care during the reporting period. See the text box on this page for information on how to calculate FTEs.

**How to calculate FTEs**

***Step One:*** Count each staff member who works full-time (generally 35–40 hours per week) on HIV/AIDS care as one FTE. Full-time employees who regularly work overtime should not be counted as more than one FTE.

If a percentage of each staff member's time is being funded by Titles I, II, III, and/or IV, simply add the percentages to calculate the total. For example: Physician .50 FTE, Nurse Practitioner 1.0 FTE, Dentist .20 FTE, Case Manager .75 FTE, Counseling & Testing 1.0 FTE = 3.45 FTEs.

***Step Two:*** Identify the staff members who do not work full-time on HIV/AIDS care (e.g., part-time employees or full-time employees who spend only a portion of their time in HIV/AIDS care), and sum the weekly hours they spend in HIV/AIDS care. Divide this number by your agency's definition of full-time (e.g., 40 hours per week).

***Step Three:*** Add the FTEs calculated in steps one and two. This sum is the number of FTEs you should report.

## SECTION 2. CLIENT INFORMATION

*This section should be completed by all agencies that provide services directly to clients and are funded through Ryan White CARE Act Titles I, II, III, and/or IV. Record numbers separately for infected and affected clients served during the reporting period.*

Clients in this section include your infected and affected population, whether receiving primary care or support services.

*Infected client*s include individuals who were HIV-positive and who received at least one Ryan White CARE Act-eligible service during the reporting period.

*Indeterminate clients* include children under age 2, born to mothers who were HIV-infected, and whose HIV status is not yet definite.

*Affected clients* include individuals who were HIV-negative as well as those with unknown HIV status. *An affected client* is a family member or partner who received at least one Ryan White CARE Act supportive or case management service during the reporting period. **This individual must be linked to an**

**infected client who is currently receiving services from your agency.**

*Family members* include children, partners, biological parents, adoptive parents, foster parents, grandparents, other caregivers, and siblings (who may or may not be living with HIV).

In Section 2, and all other sections of the CADR, check "Unknown" boxes or report "Unknown" counts only when necessary. If you report more than 10 percent of your clients with an unknown age, race/ethnicity, or HIV status (medical providers), you should examine your data collection system to determine how it can be improved to reduce this percentage.

***Remember your reporting scope.*** If you chose reporting scope "01" on page 1, Item 6, provide information on all clients, whether funded by a CARE Act grant or other funding source. If you chose reporting scope "02" on page 1, Item 6, (with the permission of the HRSA Project Officer) include only those clients who received services funded by Title I, II, III, and/or IV.

### 23. Total number of unduplicated clients

In each respective category report the total number of individuals receiving at least one Ryan White CARE Act-eligible service during the reporting period. To obtain an unduplicated client count, an individual receiving multiple units of service must be counted only once. Anonymous clients should ***not*** be reflected in this total.

*Unduplicated client count* is an accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the provider's sites.

### 24. Total number of new clients

Report the number of unduplicated clients whose first receipt of services from the provider agency occurred during this reporting period. Clients served anonymously should not be considered new clients and should not be reported in this item.

*New client* is an individual who received services from a provider for the first time ever during this reporting period. Individuals who return for care after an extended absence are not considered new unless past records of their care are not available.

**Data Quality Check**
The total number of new clients reported in Item 24 must be less than or equal to the total number of clients reported in Item 23 by category.

**NOTE:** The total number of new clients reported in Item 23 should only be equal to the total number of clients in Item 24 if the agency is newly funded by the Ryan White CARE Act.

### 25. Gender of clients

Report the actual unduplicated numbers of male, female, and transgender clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients who are HIV-positive/indeterminate and affected, reported in Item 25, must equal the total number of clients who are HIV-positive, HIV-indeterminate, and HIV-affected, reported in Item 23.

*Transgender* is an individual who exhibits the appearance and behavioral characteristics of the opposite sex and is based on self-report by that individual.

### 26. Age of clients

Report the actual unduplicated number of clients in each age group using client ages at the end of the reporting period. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 26 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

27. **Race/Ethnicity of clients**

Report the actual unduplicated number of clients in each racial and ethnic group, based on the self-report of the client. All individuals who identify themselves with more than one race should be counted in the "More than one race" category. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 27 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget (For more information go to http://www.whitehouse.gov/omb/fedreg/2005.html).

*White (not Hispanic)* is an individual having origins in any of the original peoples of Europe, the Middle East, or North Africa, but not of Hispanic ethnicity.

*Black or African American (not Hispanic)* is an individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.

*Hispanic or Latino(a)* is an individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

*Asian* is an individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

*Native Hawaiian or Other Pacific Islander* is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

*American Indian or Alaska Native* is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

*Unknown/unreported* is an individual who did not self-report either race or ethnicity.

28. **Annual household income**

Report the annual household income category of the client **at the end of the reporting period**, or report the most recent data available within the reporting period. Income is defined in ranges relative to the Federal poverty guidelines. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 28 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

*Household* includes all people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of related or unrelated people who **share** living arrangements.

*Household income* is the sum of money received in the previous calendar year by all household members, ages 15 years and older, including household members not related to the householder and people living alone.

Families and individuals are classified as below poverty level if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder, and number of related children under 18 present. Poverty status is determined for all families (and, by implication, all family members). For individuals not in families, poverty status is determined by their income in relation to the appropriate poverty threshold. Thus, two unrelated individuals living together may not have the same poverty status. The poverty thresholds are updated each year to reflect changes in the Consumer Price Index. See Poverty Guidelines, Research, and Measurement at http://aspe.hhs.gov/poverty/.

**Household income categories:**

*Equal to or below the Federal poverty level* indicates that the client's annual household income is the same as or below the Federal poverty level.

*Within 101–200% of the Federal poverty level* indicates that the client's income is equal to or no more than double the Federal poverty level.

*Within 201–300% of the Federal poverty level* indicates that the client's income is double or no more than triple the Federal poverty level.

*More than 300% of the Federal poverty level* indicates that the client's income is triple or more above the Federal poverty level.

*Unknown/unreported* indicates that the client's income is unknown or was not reported.

### 29. Housing arrangement categories

Report the number of clients according to their regular place of residence **at the end of the reporting period**, or most recent data available within the reporting period, using the categories defined below. Include infants, under the age of 2 whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 29 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

**Housing/living arrangements:**

*Permanently housed* includes clients who reside in apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

*Non-permanently housed* includes clients who are homeless, as well as those living in transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for living. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

*Institution* includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.

*Other* includes other housing/living arrangements not listed above.

*Unknown/unreported* indicates that housing/living arrangements were not reported.

### 30. Primary source of medical insurance

Report the number of clients receiving each type of medical insurance **at the end of the reporting period**, or the most recent data available for the reporting period.

Select only one form of insurance for each client. Report the medical insurance that provides the most reimbursement if a client has more than one source of insurance. If a client's only means of covering the costs of services is Ryan White CARE Act funds, report the client in the "no insurance" category. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 30 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

*Private* includes health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.

*Medicare* is a health insurance program for people ages 65 years and older, people with disabilities under age 65, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

*Medicaid* is a jointly funded, Federal-State health insurance program for people with low incomes.

*Other public* includes other Federal, State, and/or local government programs providing a broad array of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (TRICARE), State Children's Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.

*No insurance* indicates that the client has no insurance to cover the cost of services (i.e. self-pays).

*Other* indicates that the client has an insurance type other than those listed above.

*Unknown/unreported* indicates that the primary source of medical insurance is unknown and not documented.

### 31. HIV/AIDS status

Report the total number of clients by their HIV/AIDS status at the end of the reporting period. This information is required of primary medical care providers and is requested from all other providers who collect this information.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 31 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

*HIV-positive, not AIDS* clients have tested positive for and been diagnosed with HIV, but have not advanced to AIDS.

*HIV-positive, AIDS status unknown* clients have tested positive for and been diagnosed with HIV. It is unknown whether or not the client has advanced to AIDS.

*CDC-defined AIDS* clients have advanced to and been diagnosed with CDC-defined AIDS.

*HIV-indeterminate* clients are children under age 2, born to mothers who were HIV-infected, and whose HIV status is not yet definite.

*HIV-negative (affected)* clients have tested negative for HIV and are an affected partner or family member of an individual who is HIV-positive.

*Unknown (affected)* indicates the HIV/AIDS status of the client is unknown and not documented.

**NOTE:** Once a client has been diagnosed with AIDS, s/he is always counted in the CDC-defined AIDS category regardless of disease indicators (i.e., CD4 counts).

### 32. Vital/enrollment status categories

Report the number of clients with each vital/enrollment status ***at the end of the reporting period***.

**Data Quality Check**
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 32 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23. In addition, the number reported for *Active, client new to the program* should not exceed the total number of new clients reported in Item 24.

*Active client, new to the program* is an individual whose first point of contact with the program occurred during this reporting period.

*Active client, continuing in program* is an individual who was a client when the period started and continued in the program.

*Deceased* clients have died sometime during this reporting period.

*Inactive* includes, for example, clients who have moved or were lost to follow-up.

*Unknown/unreported* indicates that the vital/enrollment status is unknown or not reported.

## SECTION 3. SERVICE INFORMATION

*Service providers from all Titles should complete this section. If you offered a particular service, check the box in column 2 and list the number of clients and the total number of visits for the appropriate service categories. If you offered a particular service but do not know the number of clients or visits during the reporting period, check the "Unknown" box in the appropriate column. Include HIV-indeterminate clients in the HIV+ column.*

**NOTE:** This question lists all services eligible under the CARE Act. However some services cannot be funded under some Titles. Check your notice of grant award or call your Project Officer to determine services eligible to be funded under your Title(s).

33. **Services offered, number of clients served, and the total number of visits**

For each of the following services:

- Place a check mark in column 2 if the service was offered by your organization, either directly or via a contractual arrangement with another service provider that does not complete its own CADR.
- For all services that you offer, as indicated with a check mark in column 2, report the total number of unduplicated clients who received the service and the total number of visits made by those clients during the reporting period.
- If your program offers a particular service but did not see any clients for that service, enter a check mark in column 2 and report "0" in columns 3 and 4.
- Do not leave the columns blank.
- Do not include any anonymous/drop-in clients or visits in columns 3 and 4.

**Data Quality Check**

The number of clients reported in column 3a for any given service in Item 33 cannot exceed the total number of unduplicated clients reported in Item 23. In addition, the number of visits reported in column 4a for any given service in Item 33 must be greater than or equal to the number of clients reported for that service in column 3a.

Only Title IV funded agencies may report services to affected clients in rows a-i. If you do not receive Title IV funding, do not complete these boxes for affected clients**.**

**NOTE:** A client may only have one visit for each service category per day. For a residential substance abuse treatment center, each day in a residential facility equals one visit. For example, if a client spends 20 days in a residential facility, this counts as 20 visits.

**Service categories:**

a. *Ambulatory/outpatient medical care* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

*Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

**Data Quality Check**

The total number of clients receiving *Ambulatory/ outpatient medical care,* as reported in Item 33a, must be equal to the total number of clients reported in Item 42 in Section 5.

b. *Mental health services* are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

c. *Oral health care* are diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

d. *Substance abuse services–outpatient* is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

e. *Substance abuse services–residential* is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

f. *Rehabilitation services* are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

g. *Home health: para-professional care* is the provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help clients with disabilities remain in their homes.

h. *Home health: professional care* is the provision of services in the home by licensed health care workers such as nurses.

i. *Home health: specialized care* is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

j. *Case management services* are a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. This definition also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

k. *Buddy/companion service* is an activity provided by volunteers/peers to assist the client with performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

l. *Child care services* are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or CARE Act-related meetings, groups, or training.

**NOTE:** This does not include child care while a client is at work.

m. *Child welfare services* are the provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services may be designed to prevent the break-up of a family and to reunite family members. Foster care assistance places

children under age 21, whose parents are unable to care for them, in temporary or permanent homes, and sponsors programs for foster families. This category includes other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV-positive about risks and complications, caregiving needs, and developmental and emotional needs of children is also included.

n. *Client advocacy* is the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up of medical treatments, as case management does.

o. *Day or respite care for adults* is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client.

p. *Developmental assessment/early intervention services* are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

q. *Early intervention services for Titles I and II* are counseling, testing, and referral services to PLWHA who know their status but are not in primary medical care, or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.

r. *Emergency financial assistance* is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

s. *Food bank/home-delivered meals* is the provision of actual food, meals, or nutritional supplements. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

t. *Health education/risk reduction* is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

u. *Housing and housing-related services* are the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for clients who are HIV-affected. Category includes access to short-term emergency housing for homeless people. This also includes assessment, search, placement, and the fees associated with them.

**NOTE:** If housing services include other service categories (e.g., meals, case management, etc.), these services should also be reported in the appropriate service categories.

v. *Legal services* are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

w. *Nutrition counseling/medical nutrition therapy* is provided by a licensed registered dietitian outside of a primary care visit. Nutrition counseling/medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

x. *Outreach services* are programs that have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

y. *Permanency planning* is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

z. *Psychosocial support services* are the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse, or nutrition counseling/medical nutrition therapy that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.

aa. *Referral for health care/supportive services* is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

ab. *Referral to clinical research* is the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research are studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an institutional review board (IRB) that initially approves and periodically reviews the research.

ac. *Residential or in-home hospice care* includes room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

ad. *Transportation services* include conveyance services provided, directly or through voucher, to clients so that they may access health care or support services.

ae. *Treatment adherence counseling* is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

af. *Other services* are other services not listed above.

## SECTION 4. HIV COUNSELING AND TESTING

*Title I, II, III, and IV grantees/service providers who selected the eligible reporting scope "01", and provide HIV antibody counseling and testing, must report on all items in Section 4. Those who selected the funded reporting scope "02", and provide HIV antibody counseling and testing, but do not use CARE Act funds can answer "Yes" to Item 34 in this section, "No" to Item 35, and skip to Section 5, Item 42.*

**NOTE:** Based on Ryan White CARE Act reauthorization, HIV counseling and testing is funded as a component of Early Intervention Services for Titles I and II. HIV counseling and testing is a required component of a Title III program. Title IV funds may be used to support these services.

Report the number of individuals who received counseling and testing during the reporting period, regardless of where these services were provided (i.e., at your outpatient facilities or at another site within your program). Until these individuals receive at least one of the services listed in Section 3, they are **NOT** considered clients.

This is the ONLY section of the CADR where anonymous clients may be reported.

34. **a. HIV counseling and testing services**

Indicate whether HIV counseling and testing were provided as part of your outpatient system of care during the reporting period, either in your facilities or by procuring or subsidizing these services provided by other programs. If HIV counseling and testing services were provided, respond to Item 34a. If HIV counseling and testing services were not provided during the reporting period, do not complete Items 34b through 41 in this section, but skip to Section 5.

b. **Infant testing**

If HIV counseling and testing services were provided, indicate the total number of infants (under 2 years old) tested during this reporting period.

35. **Funding source for HIV counseling and testing services**

Indicate whether CARE Act funds were used to support HIV counseling and testing services during the reporting period, regardless of where these services were provided (i.e., at your outpatient facilities or at another site within your program).

36. **HIV pretest counseling**

Indicate the number of individuals who received each type of HIV pretest counseling (counseling before testing for HIV antibodies) by an individual qualified to provide such counseling, during the reporting period.

*Confidential* information such as name, gender, age, etc., is collected about the client, and the client is reassured that no identifying information will be shared or passed on to anyone.

*Anonymous* indicates that no identifying information is collected from the client.

If the answer to both confidential and anonymous pretest counseling is "0," skip to #41.

37. **HIV antibody testing**

Indicate the number of individuals who were tested for HIV antibodies, after being counseled, during the reporting period. Not everyone who receives HIV pretest counseling elects to be tested.

**Data Quality Check**
The total number of clients reported in Item 37 must be less than or equal to the total number of clients reported in Item 36.

38. **Positive antibody results**

Indicate the number of individuals who tested positive for HIV antibodies during the reporting period.

**Data Quality Check**
The total number of clients reported in Item 38 must be less than or equal to the total number of clients reported in Item 37.

39. **HIV posttest counseling**

Indicate the number of individuals who, after being tested for HIV antibodies, returned for HIV posttest counseling from an individual qualified to provide

such counseling, during the reporting period, regardless of their test results. This includes every individual tested for HIV, whether the test result was positive, negative, or indeterminate.

**Data Quality Check**
The total number of clients reported in Item 39 must be less than or equal to the total number of clients reported in Item 37.

40. **Did not return for HIV posttest counseling**

Indicate the number of individuals who had a positive HIV antibody test result and did not return for HIV posttest counseling, during the reporting period.

**Data Quality Check**
The total number of clients reported in Item 40 must be less than or equal to the total number of clients reported in Item 38.

41. a. **Partner notification**

Indicate by checking "Yes" if you offered partner notification services during the reporting period. If partner notification was offered through referral to another organization, or it is not offered, check "No" and then skip to Section 5. This includes notification of both sex partners and injection drug use partners.

*Partner notification* is when a clinician in your program notifies the partner of a client of possible exposure to HIV. (Check State and local laws for specific requirements of partner notification programs.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.

b. **At-risk partner notification**

Indicate the number of at-risk partners who were directly contacted by a provider to discuss their possible exposure to HIV. Do not count the number of clients counseled on disclosure issues. Do not count the number of clients who were referred to an agency that provided partner notification services. If partner notification services were provided but no partners were notified during the reporting period, report "0."

**Data Quality Check**
If '"Yes" was checked in Item 41a, a number must be reported in Item 41b.

## SECTION 5. MEDICAL INFORMATION

*This section should only be completed by medical service providers funded through Ryan White CARE Act Titles I, II, III, or IV for clients who are HIV-positive/indeterminate and had at least one ambulatory/outpatient medical care/outpatient medical care visit during the reporting period. Other individuals who have authorized access to medical information should* ***NOT*** *complete this section. A medical service provider is any service provider who provided ambulatory/ outpatient medical care (Item 33, service category "a").*

42. **Gender**

Report the number of unduplicated clients in each gender category.

**Data Quality Check**
The total number of clients reported in Item 42 must be less than or equal to the total number of HIV-positive and HIV-indeterminate clients reported in Item 23. The number of clients reported in each gender category in Item 42 must be less than or equal to the number of clients reported in each gender category in Item 25. In addition, **all** HIV+/Indeterminate clients reported in Item 33a **must** be included in Section 5.

43. **Ambulatory/outpatient medical care visits**

Report the number of unduplicated clients in each of the listed categories of number of ambulatory/outpatient medical care visits.

44. **HIV exposure category**

Report the number of unduplicated clients in each of the HIV exposure categories.

Individuals with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for individuals with a history of both homosexual/ bisexual contact and injection drug use. They are counted in a separate category.

**Data Quality Check**
The total number of clients reported in Item 44 must be equal to the total number of clients reported in Item 42.

*Men who have sex with men (MSM)* cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

*Injection drug user (IDU)* cases include individuals who report use of drugs intravenously or through skin-popping.

*MSM and IDU* cases include men who report sexual contact with men and use of drugs intravenously or through skin-popping.

*Hemophilia/coagulation disorder* cases include individuals with delayed clotting of the blood.

*Heterosexual contact* cases include individuals who report specific heterosexual contact with an individual with, or at increased risk for, HIV infection (e.g., an injection drug user).

*Receipt of transfusion of blood, blood components, or tissue* cases include transmission through receipt of infected blood or tissue products given for medical care.

*Mother with/at risk for HIV infection (perinatal transmission)* cases includes the transmission of disease from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV-positive or at risk.

*Other* indicates the individual's exposure is known, but not listed above.

*Undetermined/unknown, risk not reported or identified* indicates the individual's exposure is unknown or not reported for data collection.

### 45. New clients

Indicate the number of unduplicated clients who received HIV medical services from your agency for the first time during this reporting period.

### 46. New clients receiving CD4 and viral load counts

Indicate the number of new clients from Item 45 who received at least one CD4 count or one viral load test during the reporting period.

**Data Quality Check**
The total number of clients reported in each category in Item 46 must be less than or equal to the total number of new clients reported in Item 45.

### 47. Tuberculosis (TB) skin test

For more information about TB, refer to the Guidelines for Prevention of OIs for persons Infected with HIV: http://www.aidsinfo.nih.gov/guidelines/op_infections/OI_112801.html#tuberculosis.

#### a. Number of clients for whom a PPD skin test was indicated

Indicate the number of clients for whom a tuberculosis skin test was medically indicated during this reporting period. Do not include clients if they have had a positive TB skin test, if they have been treated for active tuberculosis, or if they received treatment of latent TB infection (LTBI) in a prior reporting period.

#### b. Receipt of PPD skin test

Indicate the number of clients reported in Item 47a who actually received a PPD skin test.

#### c. Results of TB skin tests

Indicate the number of people who received a PPD skin test (Item 47b) who had a positive, negative, or unknown result.

#### d. Started treatment of latent TB infection (LTBI) or active TB

Indicate the number of clients who received a positive PPD skin test and started treatment of LTBI, or received treatment for active TB, or were lost to follow-up.

#### e. TB treatment Status

Indicate the number of clients who received a positive PPD skin test and who completed or are currently undergoing treatment of LTBI or active TB respectively, as well as those who did not

complete the full treatment or were lost to follow-up.

**Data Quality Check**
The number of clients reported in Item 47a must be less than or equal to the total number of clients in Item 42. The number in Item 47b must be less than or equal to the number in Item 47a. The number in Item 47c must be less than or equal to the number in Item 47b. The number in Item 47d must be equal to the number in Item 47c.
Item 47e must be less than or equal to Item 47d.

### 48. Screening/Testing services

Report the total number of clients who received each of the screening/testing services listed at any time during the reporting period. Report one answer for each of the services.

**Data Quality Check**
The total number of clients in any single category in Item 48 must be less than or equal to the total number of clients reported in Item 42.

### 49. AIDS diagnoses

Report the number of clients that were diagnosed as having AIDS during the reporting period.

*AIDS* is the most severe manifestation of infection with HIV. CDC lists numerous opportunistic infections and cancers that, in the presence of HIV infection constitute an AIDS diagnosis. In 1993, CDC expanded the criteria for an AIDS diagnosis in adults and adolescents to include CD4+ cell counts at or below 200 cells per microliter in the presence of HIV infection. AIDS defining conditions include: pneumocystis carinii pneumonia (PCP), Mycobacterium avium complex (MAC), Mycobacterium tuberculosis, cytomegalovirus disease, toxoplasmosis, cervical cancer, and others. See http://aidsinfo.nih.gov for more information on AIDS diagnosis, opportunistic infections, and cell counts.

**Data Quality Check**
The total number of clients reported in Item 49 must be less than or equal to the total number of clients reported in Item 42.

### 50. Deceased clients

Of the clients reported in Item 42, indicate how many clients were known to have died during the reporting period.

### 51. Antiretroviral therapy type

Indicate the number of clients receiving each type of antiretroviral therapy. Count each client only once.

*HAART (Highly Active Antiretroviral Therapy)* is an aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV, whose purpose is to reduce viral load to undetectable levels.

*Monotherapy* refers to the use of only one antiretroviral drug.

*Dual Therapy* refers to the use of only two antiretrovirals.

*Unknown/unreported* indicates the client's therapy is unknown.

For more information on treatment guidelines visit http://www.aidsinfo.nih.gov/guidelines.

### 52. Gynecological exams

Report the total number of women (female clients) who received a pelvic exam and Pap smear during the reporting period.

**Data Quality Check**
The total number of women reported in Item 52 must be less than or equal to the total number of women (female clients) reported in Item 42.

### 53. Pregnant women

#### a. Number of pregnant women

Report the number of women who were HIV-positive and who were pregnant at any time during the reporting period, regardless of the outcome of their pregnancies.

#### b. Trimester of first visit for prenatal care

Of the number of pregnant women reported in Item 53a, list the number who entered prenatal care in each trimester of pregnancy (or at delivery).

#### c. Antiretroviral medications received by pregnant women

Report the total number of pregnant women, reported in Item 53a, who received antiretroviral medications during the reporting period.

**Data Quality Check**
The total number of women reported in Item 53a must be less than or equal to the number of women (female clients) reported in Item 42. The total number of women reported in Item 53b must be less than or equal to Item 53a. Item 53c must be less than or equal to Item 53a.

d. **Infants delivered**

Report the total number of infants delivered (live births) to pregnant women during the reporting period.

e. **HIV/AIDS status of infants**

Of the infants delivered (Item 53d), report the number in each category at the end of the reporting period.

**Data Quality Check**
The total number of infants reported in Item 53e must be equal to the total number of infants reported in Item 53d.

54. **Quality management program**

Indicate whether or not your agency has a program to manage the quality of CARE Act services. Also indicate whether or not the program has been recently introduced or updated with new standards. For further information on quality management of CARE Act services, refer to the Technical Assistance Manual available from http://hab.hrsa.gov/tools.htm.

## SECTION 6. DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV

*This section should be completed by Title III and IV grantees/service providers. All others should skip to Section 7. Part 6.1 is specific to Title III. Part 6.2 is specific to Title IV.*

### Part 6.1. Title III Information

*Part 6.1 should be completed only by Title III grantees/service providers. Include all of your Title III Early Intervention Service (EIS) clients in this table. These are clients who are HIV-positive and have received at least one primary health care service during the reporting period, regardless of the funding source for that service.*

*Each grantee defines the clients who are in the EIS program. At the very least, your definition must reflect the program you described in your last competing grant application.*

Title III defines "regardless of funding source" to mean that Title III eligible services can be funded from Title III or any other funding sources.

*Primary health care service* is any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, and pharmacy services; radiology, laboratory and other tests used for diagnosis and treatment planning.

*The number of clients reported in this section must be less than or equal to the number of clients in section 2. If the number of clients reported in this section is equal to the number in section 2 (including the demographic breakdowns), check the box and skip to Item 59.*

**Data Quality Check**
If the box is checked, the number of clients reported throughout Section 6.1 must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported in Section 2. All data quality checks will compare Section 2 data with Section 6.1 data.

55. **Unduplicated client count**

a. **HIV-positive and indeterminate clients**

Indicate the number of clients included in this section who received at least one service and are HIV-positive or HIV-indeterminate (children under age 2 only).

b. **New clients**

Of the clients in Item 55a, indicate how many were newly enrolled during this reporting period. This number must be less than the number of clients reported in Item 55a.

**Data Quality Check**
The total number of clients reported in Item 55a must be less than or equal to the total number of HIV+/indeterminate clients reported in Item 23. In addition, the number of clients reported in Item 55b must be less than or equal to the number of HIV+/indeterminate clients reported in Item 24 as well as the total number of clients reported in item 55a.

If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported in Items 23 and 24.

56. **Gender**

Report the actual unduplicated numbers of male, female, and transgender HIV-infected clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported. Do not include any anonymous clients in these counts.

**Data Quality Check**
The number of clients reported on each line in Item 56 must be less than or equal to the number of clients reported on the corresponding line in Item 25.

If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported on the corresponding line in Item 25.

57. **Age**

Report the actual unduplicated number of HIV-positive clients in each age group using client ages at the end of the reporting period. Do not include any anonymous clients in these counts. Children under age 2 who are indeterminate should be reported in this section.

**Data Quality Check**
The number of clients reported on each line in Item 57 must be less than or equal to the number of clients reported on the corresponding line in Item 26.

If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported on the corresponding line in Item 26.

58. **Race/Ethnicity**

Report the number of HIV-positive/indeterminate clients in each racial and ethnic group, based on the self-report of the client. Do not include any anonymous clients in these counts.

**Data Quality Check**
The number of clients reported on each line in Item 58 must be less than or equal to the number of clients reported on the corresponding line in Item 27.

If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported on the corresponding line in Item 27.

59. **Race/Ethnicity and gender by age**

Report the number of clients who are HIV-positive or indeterminate who received primary health care services during the reporting period by race/ethnicity, gender, and age.

**Data Quality Check**
The total number of clients reported in Item 59 must be equal to the total number of clients reported in Item 55a. In addition, the total number of clients reported in each race/ethnicity, gender and age category in Item 59 must be equal to the number of clients who are HIV+/indeterminate reported in each of the corresponding categories in Items 56 to 58.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 to 27.

60. **HIV exposure category and gender by race/ethnicity**

Report the number of clients who are HIV-positive or indeterminate who received primary health care services during the reporting period by exposure category, gender and race/ethnicity.

**Data Quality Check**
The total number of clients reported in Item 60 must be equal to the total number of clients reported in Item 55a. In addition, the total number of clients reported in each race/ethnicity and gender category in Item 60 must be equal to the number of clients reported in each of the corresponding categories in Items 56 and 58.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 and 27.

### 61. HIV exposure category and gender by age

Report the number of clients who are HIV-positive or indeterminate who received primary health care services during the reporting period by exposure category, gender, and age.

**Data Quality Check**

The total number of clients reported in Item 61 must be equal to the total number of clients reported in Item 55a. In addition, the total number of clients reported in each gender and age category in Item 61 must be equal to the number of clients reported in each of the corresponding categories in Items 56 and 57.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 and 26.

### 62. Cost and revenue

Your response to each of the following items will indicate the cost of or revenue for providing "Primary care" and "Other program" services as defined below.

*Primary care* is any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; HIV counseling and testing; and the cost of making and tracking referrals for medical care.

*Other program,* for Title III reporting purposes, refers to optional services that are eligible for Title III funds. Examples include case management, eligibility assistance, social work, outreach, CME, etc. Check the line-item budget on your last approved application for clarity. Do NOT include any administrative costs, expenditures, or revenues. Include any Title III eligible service, even if it is not being *funded* under your grant.

#### a. Total cost of providing service

Indicate the total cost (personnel, supplies, rent, etc.) to the EIS program of providing each category of service during the reporting period. Each dollar figure should be representative of the amount of money it takes to provide the service as part of the EIS program.

These amounts are independent of funding sources and will give some indication of what it costs to provide HIV-related care. Do not leave any line blank.

#### b. Title III grant funds expended

Indicate the amount of the Title III funds expended to support each category of service during the reporting period. This is the amount of Title III monies used to cover part of the total cost of providing each service. If Title III money was not used to support a particular service, report "0." Do not leave any line blank.

#### c. Direct collections from clients

Indicate the amount of money collected directly from clients as payment for services provided during the reporting period. This would include any out-of-pocket payment from clients such as co-payments, deductibles, nominal per-visit fees, etc. This is the amount of money received from clients that is used to cover part of the total cost of providing each service. If direct collections from clients are not received or used to support a particular service, report "0." Do not leave any line blank.

#### d. Reimbursements

Indicate the amount of reimbursements received from third-party payers (public and private) as payment for services provided during the reporting period. This includes reimbursements from Medicaid, private insurance, VA benefits, etc. This is the amount of money that is used from third-party payers to cover part of the cost of providing each service. If third-party money is not used to support a service, report "0." Do not leave any line blank.

#### e. Other sources of income

Indicate the amount of other sources of income or revenue (other than Ryan White CARE Act Title III, direct collections from clients, and reimbursements received from third-party payers, as

reported in Item 62c, and Item 62d) that was used during the reporting period to support services in your EIS program. This is the amount of money that was used from other sources of income to cover part of the cost of providing each service. Other sources may be from city, county, or State agencies; academic institutions, foundations, and corporations; and fundraising activities, bequests, and donations. Include any other Ryan White CARE Act funding, such as Title I, Title II, or Title IV, and any other Federal agency funding (CDC, SAMHSA, BPHC, etc.) used to support any category of service. If these other sources of income did not provide money to support EIS services, report "0." Do not leave any line blank.

**Data Quality Check**
Funds reported in Item 62b, c, d, and e for the categories of "Primary care" and "Other program" should not exceed the cost of providing services in the corresponding categories in Item 62a.

63. **a. Early Intervention Services sites**

Check whether or not the grantee organization provided Early Intervention Services (EIS), that is, Title III-eligible services, at more than one site during the reporting period.

b. **Number of EIS sites**

If you answered "Yes" to Item 63a, indicate the number of sites at which EIS were provided during the reporting period.

64. **Available services**

Check whether each primary health service was available to clients who are HIV-positive, within the EIS program and/or through referral to providers outside of the EIS program, during the reporting period.

*EIS program* encompasses the care supported by the Title III legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization and are reimbursed for their services or otherwise have a remunerative relationship with the grantee for the referred service.

*Outside the EIS Program* is a referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Title III grantee or its parent organization.

It is not necessary to indicate how many clients received each service or how many client visits were made to obtain each service. All the services you have indicated may not have been utilized during the reporting period. However, the services you have indicated should have been available if a client had required them within the EIS program and/or through referral. If services other than those listed here were available, check "Other services." See list below for description of services.

**Description of services:**

*Ambulatory/outpatient medical care* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to, and provision of, specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

*Dermatology* refers to care related to the skin.

*Dispensing of pharmaceuticals* is the provision of prescription drugs to prolong life or prevent deterioration of health.

*Gastroenterology* refers to the care related to the stomach and intestines.

*Mental health services* include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual

setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

*Neurology* refers to care related to the nervous system.

*Nutrition counseling/medical nutrition therapy* includes services provided by a licensed/registered dietitian outside of a primary care visit. Nutrition counseling/ medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

*Obstetrics/gynecology* refers to care related to the female reproductive organs as well as pregnancy.

*Optometry/ophthalmology* refers to care related to the eye.

*Oral health care* includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

*Rehabilitation services* include services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

*Substance abuse services* include the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

*Other services* include other Title III-eligible, primary care services not listed above.

65. **Referrals outside the EIS program**

Report the total number of unduplicated clients who are HIV-positive and were referred outside of the EIS program for any primary health care service not available within the EIS program during the reporting period. This number should be a subset of all clients who received at least one primary health care service in the program during the reporting period. If no clients were referred outside the program during the reporting period, report "0." Do not leave the line blank.

## Part 6.2. Title IV Information

*Part 6.2 should be completed only by Title IV grantees/service providers. Report only on the Title IV clients who are **HIV-infected and affected** (a family member or partner of a client who is HIV-positive). The number of clients reported in this section must be less than or equal to the number reported in section 2. If the number of clients reported in this section is equal to the number in section 2 (including the demographic breakdowns), you may check the box and skip to question 71.*

**Data Quality Check**
If the box is checked, the number of clients reported in Section 6.2 must be **EQUAL** to the number of clients reported in Section 2. All data quality checks will compare Section 2 data with Section 6.2 data.

*Title IV programs are designed to provide family-centered care and services to women, infants, children, and youth with HIV disease and their affected family members.*

*If your Title IV project works with partners that provide care and services to many different individuals with HIV/AIDS, report ONLY those services they provide to Title IV clients in section 6.2.*

66. **Unduplicated client count**

Provide the unduplicated number of Title IV clients who are HIV-positive, HIV-indeterminate, or HIV-negative/unknown. Children under age 2 with undetermined status should be listed as "indeterminate."

**Data Quality Check**
The total number of clients reported in Item 66 must be less than or equal to the number of clients in each of the corresponding categories in Item 23.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 23.

67. **New clients**

Of the clients reported in the question above, indicate the number in each category who were enrolled for the first time during this reporting period.

**Data Quality Check**
The total number of clients reported in Item 67 must be less than or equal to the number of clients reported in each of the corresponding categories in Items 24 and 66.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 24.

68. **Gender**

Report the actual unduplicated numbers of male, female, and transgender clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported for HIV-positive and HIV-negative/unknown clients. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients reported in Item 68 must be less than or equal to the number of clients reported in each of the corresponding categories in Item 25.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 25.

69. **Age**

Report the actual unduplicated numbers of clients in each group and the number of clients for whom age is unknown or unreported for HIV-positive/indeterminate and HIV-negative/unknown clients. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients reported in Item 69 must be less than or equal to the number of clients reported in each of the corresponding categories in Item 26.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 26.

70. **Race/Ethnicity**

Report the number of HIV-positive/indeterminate and number of HIV-negative/unknown clients in each category, based on their self-report. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients reported in Item 70 must be less than or equal to the number of clients reported in each of the corresponding categories in Item 27.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 27.

71. **Gender and HIV status by age**

Report the number of clients during the reporting period by gender, HIV status, and age.

**Data Quality Check**
The total number of clients reported in Item 71 must be equal to the total number of clients reported in Item 66. In addition, the total number of clients reported in each gender and age category in Item 71 must be equal to the number of clients reported in each of the corresponding categories in Items 68 and 69.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 and 26.

72. **Race/Ethnicity and HIV status by age**

Report the number of clients during the reporting period by race/ethnicity, HIV status, and age.

**Data Quality Check**
The total number of clients reported in Item 72 must be equal to the total number of clients reported in Item 66. In addition, the total number of clients reported in each race/ethnicity and age category in Item 72 must be equal to the number of clients reported in each of the corresponding categories in Items 69 and 70.

If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 26 and 27.

73. **Exposure category by age**

Report the number of clients who are HIV-positive/indeterminate by exposure category and age.

**Data Quality Check**
The total number of clients reported in Item 73 must be equal to the total number of clients who are HIV+/indeterminate reported in Item 66. In addition, the total number of clients reported in each age category in Item 73 must be equal to the number of clients who are HIV+/indeterminate reported in Item 69.

If the box is checked, the number of clients reported must be **EQUAL** to the number of HIV+/indeterminate clients reported in each of the corresponding categories in Item 26.

## SECTION 7. HEALTH INSURANCE PROGRAM (HIP) INFORMATION

*This section should be completed by the state agency and other entities that used CARE Act funds, except funds from ADAP, to pay for or supplement a client's health insurance. This section should not be completed by CARE Act grantees providing funding to another HIP, or by service providers who only provide vouchers for health insurance.* ***Data on health insurance programs funded through ADAP should be reported in the ADAP Quarterly Reports.***

*A Health Insurance Program is a program authorized and primarily funded under Title I or Title II of the CARE Act that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.*

74. **Total number of unduplicated clients**

Report the total number of unique clients for whom the HIP made at least one premium payment, deductible payment, co-payment, or risk pool payment during the reporting period. Do not include any anonymous clients in this count. In an unduplicated client count, an individual receiving multiple services must be counted only once. *Client counts should be unduplicated across multiple provider sites.*

*Unduplicated client count* is an accounting of clients in which a single individual is counted only once.

75. **Total number of new clients**

Report the number of unduplicated clients whose first receipt of HIP services occurred during the reporting period. Clients served anonymously should not be considered new clients and should not be reported in this item.

**Data Quality Check**
The total number of new clients reported in Item 75 must be less than or equal to the total number of clients reported in Item 74.

76. **Gender of clients**

Report the actual unduplicated numbers of male, female, and transgender clients and the number of clients for whom gender is unknown or unreported. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients reported in Item 76 must be equal to the total number of clients reported in Item 74.

77. **Age of clients**

Report the actual number of unduplicated clients in each age group using client ages at the end of the reporting period. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients reported in Item 77 must be equal to the total number of clients reported in Item 74.

78. **Race/Ethnicity**

Report the actual number of unduplicated clients in each racial/ethnic group based on client self-report. All individuals who identify themselves with more than one race should be counted in the "More than one race" category. Do not include any anonymous clients in these counts.

**Data Quality Check**
The total number of clients reported in Item 78 must be equal to the total number of clients reported in Item 74.

The following racial category descriptions, defined in October 1997, were required for all Federal reporting beginning in 2003, as mandated by the Office of Management and Budget (See http://www.whitehouse.gov/omb/fedreg/2005.html for more information).

*White (not Hispanic)* is an individual having origins in any of the original peoples of Europe, the Middle East or North Africa, but not of Hispanic ethnicity.

*Black or African American (not Hispanic)* is an individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.

*Hispanic or Latino/a* is an individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

*Asian* is an individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

*Native Hawaiian or Other Pacific Islander* is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

*American Indian or Alaska Native* is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

*Unknown/unreported* indicates an individual did not identify his/her race/ethnicity.

79. **Annual expenditures for HIP**

Report specific HIP activities and expenditures in this section. For each service your program offers (e.g., premium payments) report the total cost of providing that service, the number of unduplicated clients receiving that service during the reporting period, and the total client-months for which the program provided that service.

*Total client-months* is a calculation obtained by adding together the number of months that either a premium, deductible, or co-pay was made for each unduplicated client (e.g. if an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months).

80. **Total expenditures**

Report the Total Health Insurance Expenditures from Item 79, plus any other administrative costs.

81. **Annual HIP funding by CARE Act sources:**

Enter the HIP funding received from each of the listed sources. An EMA is an eligible metropolitan area. See the EMA codes in the table on the next page.

All HIV/AIDS HIP funding should be annualized to reflect the reporting period. See the method provided in the text box on this page.

82. **Funding for HIP by other sources**

Enter the funding received from each of the listed sources.

All HIV/AIDS HIP funding received from other sources should be annualized to reflect the reporting period. See the method provided in the text box on this page.

**Calculating Annual Fiscal Information***

**Example:**

*Annualizing fiscal information*—A provider received funding from these sources in 2005:

- $120,000 from Source A for a fiscal year beginning 10/1/2004 and ending 9/30/2005.
- $240,000 from Source B for a fiscal year beginning 10/1/2004 and ending 9/30/2005.
- $120,000 from Source C for the time period 12/1/2004 through 11/30/2005**.**

**Source A:**

- $120,000 / 12 months = **$10,000** per month x 9 months (January–September) of 2005 = **$90,000**

**Source B:**

- $240,000 / 12 months = $**20,000** per month x 3 months (October–December) of 2005 = **$60,000**

**Source C:**

- $120,000 / 12 months = **$10,000** per month x 11 months (January–November) of 2005 = **$110,000**

**Total funding for the 2005 :**

- Reporting period = $90,000 from Source A + $60,000 from Source B + $110,000 from Source C = **$260,000**

***NOTE: This information is being "annualized" and may or may not equal the amount received in the funding cycle.**

**EMA codes:**

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| Anaheim/ Orange Co. | 9923 |
| Atlanta | 9910 |
| Austin/ Travis County | 9935 |
| Baltimore | 9918 |
| Boston | 9914 |
| Caguas, PR | 9936 |
| Chicago | 9909 |
| Cleveland/ Lorain | 9943 |
| Dallas | 9913 |
| Denver | 9926 |
| Detroit | 9924 |
| Dutchess County | 9937 |
| Fort Lauderdale | 9912 |
| Ft. Worth/ Arlington | 9944 |
| Hartford | 9945 |
| Houston | 9906 |
| Jacksonville | 9938 |
| Jersey City | 9916 |
| Kansas City | 9927 |
| Las Vegas | 9954 |
| Los Angeles | 9903 |
| Miami | 9905 |
| Middlesex/ Somerset | 9946 |
| Minneapolis/ St. Paul | 9947 |
| Nassau/Suffolk | 9922 |
| New Haven/ Fairfield | 9928 |

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| New Orleans | 9919 |
| New York | 9901 |
| Newark | 9904 |
| Norfolk | 9953 |
| Oakland | 9917 |
| Orlando | 9929 |
| Passaic/Bergen | 9932 |
| Philadelphia | 9911 |
| Phoenix | 9930 |
| Ponce, PR | 9925 |
| Portland | 9939 |
| Riverside/ San Bernardino | 9931 |
| Sacramento | 9948 |
| San Antonio | 9940 |
| San Diego | 9915 |
| San Francisco | 9902 |
| San Jose | 9949 |
| San Juan | 9908 |
| Santa Rosa/ Petaluma | 9941 |
| Seattle | 9920 |
| St. Louis | 9933 |
| Tampa/ Saint Petersburg | 9921 |
| Vineland/Millville | 9942 |
| Washington D.C. | 9907 |
| West Palm Beach | 9934 |

# GLOSSARY OF CARE ACT DATA REPORT TERMS

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| **Active client continuing in program** | An individual who was a client when the period started and continued in the program. |
| **Active client new to the program** | A client whose first point of contact with the program occurred during this reporting period. |
| **ADAP** | *AIDS Drug Assistance Program*—A State-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare. |
| **ADAP Flexibility Policy** | HIV/AIDS Bureau's (HAB) Policy Notice 00-02 provides grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications.<br><br>**NOTE:** Grantees ***must*** request in writing to use ADAP dollars for services other than medications. |
| **Administrative or technical support** | The provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities). |
| **Affected client** | A family member or partner of an infected client who receives at least one Ryan White CARE Act supportive or case management service during the reporting period. |
| **Agency reporting for multiple fee-for-service provider** | An agency that reports data for more than one fee-for-service provider. |
| **Aggregate data** | Combined data, composed of multiple elements, often from multiple sources. For example, combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics. |
| **AIDS** | *Acquired immune deficiency syndrome*—A disease caused by the human immunodeficiency virus. |
| **Ambulatory outpatient medical care** | The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the guidelines published by the Public Health Service. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. |
| **American Indian or Alaska Native** | An individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. |
| **Anonymous client** | No identifying information is collected from the client. |

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| **APA** | *AIDS Pharmaceutical Assistance*—A local pharmacy assistance program implemented by a Title I EMA or Title II State. The Title II grantee consortium or Title I planning council contracts with one or more organizations to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White (or other funding sources) contract with their grantee. (See **ADAP** and **Local/Consortium Drug Reimbursement Program**) |
| **ARV** | *Antiretroviral*—A substance that fights against a retrovirus, such as HIV. (See **retrovirus**) |
| **Asian** | An individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. |
| **Black or African American (not Hispanic)** | An individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity. |
| **Buddy/companion service** | An activity provided by volunteers/peers to assist the client in performing household or personal tasks, and providing mental and social support to combat the negative effects of loneliness and isolation. |
| **Capacity development** | A set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include: management of program finances; effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; service evaluation; and cultural competency development. |
| **CARE Act** | Ryan White *Comprehensive AIDS Resources Emergency Act*—The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWHA) disease and their families in the United States and its Territories. The CARE Act was enacted in 1990 (Pub. L. 101-381), reauthorized in 1996 as the Ryan White CARE Act Amendments of 1996, and reauthorized again in 2000 as the Ryan White CARE Act Amendments of 2000. |
| **Case management services** | A range of client-centered services that links clients with health care, psychosocial and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. The definition includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan; and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services. |
| **CDC** | *Centers for Disease Control and Prevention*—The DHHS agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS Surveillance Report. |
| **CD4 or CD4+ cells** | Also known as "helper" T-cells, these cells are responsible for coordinating much of the immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections. |

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| **CD4 cell count** | The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1,500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm$^3$. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS. |
| **CEO** | *Chief Elected Official*—The official recipient of Title I CARE Act funds within the EMA, usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the CARE Act in the EMA and ensuring that all legal requirements are met. In EMAs with more than one political jurisdiction, the recipient of Title I CARE Act funds is the CEO of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of people with AIDS in the EMA. |
| **Child care services** | The provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending CARE Act-related meetings, groups, or training. This does not include child care while the client is at work. |
| **Child welfare services** | The provision of family preservation/unification, foster care, parenting education, and other child welfare services. Designed to prevent the break-up of a family and to reunite family members. Foster care assistance places children under age 21, whose parents are unable to care for them, in temporary or permanent homes, and sponsors programs for foster families. Includes other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Involves presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV-positive about risks and complications, caregiving needs, and developmental and emotional needs of children. |
| **Client** | (See **infected client** or **affected client**) |
| **Client advocacy** | The provision of advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and medical treatment follow-ups, as case management does. |
| **Combination therapy** | Two or more drugs or treatments used together to achieve optimum results against HIV infection and/or AIDS. For more information on treatment guidelines, visit http://www.aidsinfo.nih.gov/guidelines. |
| **Co-morbidity** | A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease. |
| **Confidential** | Information such as name, gender, age, etc., that is collected on the client, and the client is reassured that no identifying information will be shared or passed on to anyone. |
| **Consortium/HIV Care Consortium** | An association of one or more public, and one or more nonprofit private, health care, and support service providers, people with HIV/AIDS, and community-based organizations operating within areas determined by the State to be most affected by HIV disease. The consortium agrees to use Title II grant assistance to plan, develop, and deliver (directly or through agreement with others) comprehensive outpatient health and support services for individuals with HIV disease. Agencies comprising the consortium are required to have a record of service to populations and sub-populations with HIV. |
| **Continuum of care** | An approach that helps communities plan for, and provide, a full range of emergency and long-term service resources to address the various needs of PLWHA. |
| **Day or respite care for adults** | Community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of an adult client. |

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| **DCBP** | *Division of Community-Based Programs*—The division within HRSA's HIV/AIDS Bureau that is responsible for administering Title III, Title IV, and the HIV/AIDS Dental Reimbursement Program. |
| **Developmental assessment/early intervention services** | The provision of professional early intervention by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provides information about access to Head Start services, appropriate educational setting for HIV-affected clients and education/assistance to schools. |
| **Dispensing of pharmaceuticals** | The provision of prescription drugs to prolong life or prevent deterioration of health. |
| **DSP** | *Division of Science and Policy*—The division within HRSA's HIV/AIDS Bureau which serves as the principal source of program data collection and evaluation, the development of innovative models of HIV care, and the focal point for coordination of program performance activities and development of policy guidance. |
| **DSS** | *Division of Service Systems*—The division within HRSA's HIV/AIDS Bureau that is responsible for administering Title I and Title II including the AIDS Drug Assistance Program (ADAP). |
| **DTTA** | *Division of Training and Technical Assistance*—The division within HRSA's HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau. |
| **Dual therapy** | The use of two antiretroviral drugs at one time to reduce the amount of detectable HIV. |
| **Early intervention** | (See **HIV/EIS**—*HIV/Early Intervention Services/Primary Care)* |
| **EIS for Titles I and II** | *Early intervention services for Titles I and II* are a combination of services that include outreach, HIV counseling, testing, referral and provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care. |
| **Eligibility criteria** | The standards set by a State ADAP, usually through an advisory committee, to determine who receives access to ADAP services. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs. |
| **EMA** | *Eligible Metropolitan Area*—The geographic area eligible to receive Title I CARE Act funds. The boundaries of the eligible metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the CDC. Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend across more than one State. |
| **Emergency financial assistance** | The provision of short-term payment for essential utilities and for medication assistance when other resources are not available. |
| **Epidemic** | A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water. |
| **Exposure category** | (See **risk factor**) |
| **Faith-based organization** | An organization that is owned and operated by a religiously affiliated entity, such as a Catholic hospital. |

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| **Family centered** | A model in which systems of care under Ryan White Title IV are designed to address the needs of PLWHA and affected family members as a unit, by providing or arranging for a full range of services. The family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers. |
| **Family members** | Includes children, partners, biological parents, adoptive parents, foster parents, grandparents, other caregivers, and siblings (who may or may not be living with HIV). |
| **Fiscal intermediary services** | Reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts. |
| **Food bank/home-delivered meals** | The provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. |
| **FTE** | *Full-time equivalent*—A standard measurement of full-time staff (either paid or volunteer), which is based on a 35 to 40 hour work week. It is calculated by taking the sum of all hours worked by staff and dividing by 35 to 40, depending on how your organization defines full-time employment. For example, 2 staff members who work 20 hours each per week represent 1 FTE, assuming full-time employment is defined as 40 hours per week. |
| **Grantee of record** | The official Ryan White CARE Act grantee that receives Federal funding directly from the Federal government (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted. |
| **HAART** | *Highly active antiretroviral therapy*—An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels. |
| **HAB** | *HIV/AIDS Bureau*— The Bureau within the Health Resources and Services Administration (HRSA) of the DHHS that is responsible for administering the Ryan White CARE Act. Within HAB, the Division of Service Systems administers Title I, Title II, and the AIDS Drug Assistance Program (ADAP); the Division of Community-Based Programs administers Title III, Title IV, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau's Division of Science and Policy administers the SPNS Program, HIV/AIDS evaluation studies, and the CARE Act Data Report. |
| **Health education/risk reduction** | The provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling, to help clients with HIV improve their health status. |
| **Hemophilia/ coagulation disorder** | Individuals with delayed clotting of the blood. |
| **Heterosexual contact** | Individuals who report specific heterosexual contact with an individual with, or at increased risk for, HIV infection (e.g., an injection drug user). |
| **High-risk insurance pool** | A State health insurance program that provides coverage for individuals who are denied coverage due to a pre-existing condition or who have health conditions that would normally prevent them from purchasing coverage in the private market. |
| **HIP** | *Health Insurance Program*—a program of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles. |
| **Hispanic or Latino/a** | An individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race. |

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| **HIV counseling and testing** | The delivery of HIV counseling to an individual. Counseling includes pretest and posttest counseling activities (e.g., offering the individual the HIV antibody test, as appropriate; services discussing the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; reviewing the provisions of laws relating to confidentiality, including information regarding any disclosures that may be authorized under applicable law, and information regarding the availability of anonymous counseling and testing; and discussing the significance of the results, including the potential for developing HIV disease). Testing refers to antibody tests administered by health professionals to ascertain and confirm the presence of HIV infection (includes ELISA and Western Blot).<br><br>Counseling and testing ***does not*** include tests to measure the extent of the deficiency in the immune system because these tests are fundamental components of comprehensive primary care. This service category also excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are listed separately. |
| **HIV disease** | Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus. |
| **HIV/AIDS status** | The outcome of the client's HIV test result, which includes (1) HIV-positive not AIDS—client has tested positive for and been diagnosed with HIV, but has not advanced to AIDS; (2) HIV-positive AIDS status unknown—client has tested positive for and been diagnosed with HIV, but it is unknown whether or not the client has advanced to AIDS; (3) CDC-defined AIDS—client has advanced to and been diagnosed with CDC-defined AIDS; (4) HIV-negative (affected)—client is HIV-negative and is an affected individual of an HIV-positive partner or family member; and (5) unknown—HIV/AIDS status of the client is unknown and not documented. |
| **HIV/EIS** | *HIV/Early Intervention Services/Primary Care*—A program that encompasses the care supported by the Title III legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization, and are reimbursed for their services, or otherwise have a remunerative relationship with the grantee for the referred service. |
| **Home health: Para-professional care** | The provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes. |
| **Home health: professional care** | The provision of services in the home by licensed health care workers such as nurses. |
| **Home health: specialized care** | The provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies. |
| **Hospital or university-based clinic** | Includes ambulatory/outpatient care/outpatient medical care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs. |
| **Household** | All people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of unrelated people who share living arrangements. |
| **Household income** | The sum of money received in the previous calendar year by all household members 15 years old and over, including household members not related to the householder, people living alone, and others in non-family households. |
| **Housing assistance** | This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for short-term or emergency housing must be linked to medical and/or healthcare or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment. |

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| **Housing or housing-related services** | *Housing related services* includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed. |
| **HRSA** | *Health Resources and Services Administration*—The DHHS agency that is responsible for directing national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is also responsible for administering the Ryan White CARE Act. |
| **IDU** | *Injection drug user*—Individuals who report use of drugs intravenously or through skin-popping. |
| **Inactive client** | A client whose status is inactive (as defined by your agency), which includes many possible reasons (e.g., client moved or is lost to follow-up). |
| **Indeterminate client** | A child under the age of 2 whose HIV status is not yet determined, but was born to an HIV-infected mother. |
| **Infected client** | An individual who is HIV-positive who receives at least one Ryan White CARE Act-eligible service during the reporting period. |
| **Inpatient setting** | This includes hospitals, emergency rooms and departments, and residential facilities where clients typically receive food and lodging as well as treatments. |
| **Institution** | This includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses. |
| **LTBI** | Latent Treatment of Mycobacterium tuberculosis infection (LTBI) prevents the development of active disease and has been an essential component of tuberculosis (TB) control in the United States for several decades. |
| **Legal services** | The provision of services to individuals with respect to powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. |
| **Local county or State health department** | Publicly funded health department administered by a local, county, or State government. |
| **MAI** | *Minority AIDS Initiative*—A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development. |
| **Medicaid** | A jointly funded, Federal-State health insurance program for certain low-income and needy people. |
| **Medicare** | A health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). |
| **MSM** | *Men who have sex with men*—Men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). |

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| **Mental health services** | Psychological and psychiatric treatment and counseling services, for individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. |
| **Monotherapy** | The use of only one antiretroviral drug to reduce the amount of detectable HIV. |
| **More than one race** | An individual who identifies with more than one racial category. |
| **Mother with/at risk for HIV infection (perinatal transmission)** | Transmission of disease from mother to child during pregnancy. |
| **Native Hawaiian or Other Pacific Islander** | An individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. |
| **New clients** | Individuals who received services from a provider for the first time ever during this reporting period. Individuals who returned for care after an extended absence are not considered to be new unless past records of their care are not available. |
| **Non-permanent** | Includes individuals who are homeless, as well as transient or in transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for sleeping. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program. |
| **Nutrition counseling/medical nutrition therapy** | The provision of nutrition education and/or counseling by a licensed registered dietitian outside of a primary care visit. Nutrition counseling/medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under "Psychosocial support services." |
| **OI** | *Opportunistic infection*—An infection or cancer that occurs in individuals with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections. |
| **OMB** | *Office of Management and Budget*—The office within the executive branch of the Federal Government, which prepares the President's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews Government regulations. |
| **Oral health care** | Includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers. |
| **Other community-based service organization** | Includes non-hospital-based organizations, AIDS service and volunteer organizations, private non-profit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers. |
| **Outpatient setting** | A hospital, clinic, medical office, or other place where clients receive health care services, but do not stay overnight. |
| **Outreach services** | Programs that have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation. |

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| **Outside the EIS program** | A referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Title III grantee or its parent organization. |
| **Partner Notification** | A service provided by a clinician in your program to notify the partner of a client of possible exposure to HIV. (Check State and local laws for specific requirements.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service. |
| **Permanency planning** | The provision of services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them. |
| **Permanent housing** | Includes apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited. |
| **PHSA** | *Public Health Service Act.* |
| **Planning or evaluation** | The systematic collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, needed improvements have been identified, and/or decisions about future programming have been made. |
| **PLWHA coalition** | *People living with HIV/AIDS coalition*—Organizations of people living with HIV/AIDS that provide support services to individuals and families infected with and/or affected by HIV and AIDS. |
| **Primary health care service** | Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing. |
| **Private health insurance** | Health insurance plans such as Blue Cross/Shield, Kaiser Permanente, Aetna, etc. |
| **Private, for-profit ownership** | The organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization. |
| **Private, nonprofit (not faith-based)** | The organization is owned and operated by a private, not-for-profit, non-religious-based entity, such as a non-profit health clinic. |
| **Prophylaxis** | Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control (secondary prophylaxis). |
| **Provider agency/ service provider** | The agency that provides direct services to clients (and their families) that are funded by the Ryan White CARE Act. Services may be funded through one or more Federal Ryan White CARE Act grants, or through subcontract(s) with official Ryan White CARE Act grantees. A provider may also be a grantee such as in Titles III and IV. |
| **Psychosocial support services** | The provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, play, and other rehabilitation therapies), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse, or nutrition counseling/medical nutrition therapy that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems. |
| **Public/Federal ownership** | The organization is funded and operated by the Federal Government. An example is a Federal agency. |

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| **Public/local ownership** | The organization is funded and operated by a local government entity. An example is a city health department. |
| **Public/State ownership** | The organization is funded and operated by a State government entity. An example is a State health department. |
| **Publicly funded community health center** | Includes community health centers, migrant health centers, rural health centers, and homeless health care centers. |
| **Publicly funded community mental health center** | A community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people. |
| **Quality management** | A systematic process with identified leadership, accountability, and dedicated resources that uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized. |
| **Referral for health care/supportive services** | The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program. |
| **Referral to clinical research** | The provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research. |
| **Referrals for health services** | The act of directing a client who is HIV-positive to a health service not available within an EIS program. For the purposes of Title III data reporting, the process of making a referral is independent of the health service provided, and does not require evidence that the client actually received the service for which he or she was referred. However, if the service that the client is being referred for is paid for by the EIS program, then the cost of providing referral services should be reported. Title III funds can be used to pay for the costs associated with making the referral, as well as to pay for the services for which the client was referred. The referrals reported by Title III programs should be referrals for health services provided outside of the EIS program. Case management and other referrals for social or support services should not be reported in the *Referrals* section, nor should they be factored into the cost of providing referral services. Examples of health services for which clients may be referred outside of the EIS program include primary health care or specialty health services, any diagnostic health services such as radiology, lab tests, mental health evaluations, biopsies, and so forth. |
| **Rehabilitation services** | Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training. |
| **Reporting period** | A calendar year, January 1 through December 31 of the reporting year. The reporting period may be shorter than a year if a provider agency did not receive CARE Act Title funding for an entire calendar year. |

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| **Reporting scope** | Code 01 is the reporting scope for providers reporting ELIGIBLE services. Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Title I, II, III, or IV funding are included in the report even if the service was not paid for with Ryan White Title I, II, III, or IV funds. This reporting scope is preferred by HRSA.<br>Code 02 is the reporting scope for providers reporting FUNDED clients. Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White I, II, III, or IV funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must have an adequate mechanism for tracking clients and services by funding stream and have secured prior approval from their grantee in consultation with HRSA. |
| **Residential or in-home hospice care** | Hospice services provided through home-based hospice care, including nursing care, counseling, physician services, and palliative therapeutics to clients in the terminal stages of illness in their home setting. Services provided to clients in the terminal stages of illness in a residential setting, including non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal clients include: room, board, nursing care, counseling, physician services, and palliative therapeutics. |
| **Retrovirus** | A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material. |
| **Risk factor or risk behavior/exposure category** | Behavior or other factor that places an individual at risk for disease. For HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work. |
| **Section 330 of PHSA** | Supports the development and operation of community health centers that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations. |
| **Self-pay** | A client pays out of pocket for the majority of his or her health care costs. |
| **Solo/group private medical practice** | Includes all health and health-related private non-profit practitioners and practice groups. |
| **SPNS** | *Special Projects of National Significance*—A health services demonstration, research, and evaluation program funded under Part F of the CARE Act. SPNS projects are awarded competitively. |
| **STI** | *Sexually transmitted infection*—Infections spread by the transfer of organisms from person to person during sexual contact. |
| **Substance abuse treatment center** | An agency that focuses on the delivery of substance abuse treatment services. |
| **Substance abuse services–outpatient** | The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal or illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or other qualified personnel. |
| **Substance abuse services–residential** | The provision of treatment to address substance abuse (including alcohol and/or legal and illegal drugs) problems provided in an inpatient health service setting (short term). |
| **Target population** | A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics. |
| **Taxpayer ID #** | The unique nine-digit number issued to an organization or agency by the Internal Revenue Service for use in connection with filing requirements. This may be the same as your Employer Identification Number (EIN). |

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| **TB skin test (PPD Mantoux)** | The abbreviation for purified protein derivative (PPD), a substance used in intradermal testing for tuberculosis. |
| **Technical assistance or TA** | The identification of need for and delivery of practical program and technical support to the CARE Act community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act supported planning and primary care service delivery systems. |
| **Title I** | The part of the Ryan White CARE Act that provides direct financial assistance to designated EMAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related: (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities. |
| **Title II** | The part of the Ryan White CARE Act that authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. The CARE Act emphasizes that such care and support is part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States. |
| **Title III** | The part of the Ryan White CARE Act that provides support for early intervention services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This support includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management, and eligibility assistance. |
| **Title IV** | The part of the Ryan White CARE Act that supports coordinated services and access to research for women, infants, children, and youth with HIV disease and their affected family members. |
| **Title IV Adolescent Initiative** | A separate grant under the Title IV program that is aimed at identifying adolescents who are HIV-positive and enrolling them in care. |
| **Transgender** | An individual who exhibits the appearance and behavioral characteristics of the opposite sex. |
| **Total client-months** | A calculation obtained by adding together the number of months that a premium, deductible, or co-pay was made for each unduplicated client. (e.g., If an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months.) |
| **Transmission category** | A grouping of disease exposure and infection routes. In relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, etc. |
| **Transportation services** | Conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services. |
| **Treatment adherence services** | Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments. |
| **Unduplicated client count** | An accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the providers' sites. |

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| **URN** | *Unique record number—A* nine-digit encrypted record number following HRSA's URN specifications that distinguishes the client from all other clients and that is the same for the client across all provider settings. The URN is constructed using the first letter of the first name, the third letter of the first name (if blank use middle initial, if no middle initial use '9'), first letter of the last name, third letter of the last name (if blank, use '9'), month of birth, day of birth, and gender code. This string is then encrypted using a HRSA-supplied algorithm that can be incorporated into the provider's data collection system. |
| **VA facility** | Any facility funded through the Veterans Administration. |
| **Viral load test** | A test that measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression. |
| **White (not Hispanic)** | An individual having origins in any of the original peoples of Europe, the Middle East, or North Africa, but not of Hispanic ethnicity. |

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